U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 31 January 2005

Case No.: 2003-BLA-5058

In the Matter of:

DONALD MACK QUINLEY,
Claimant

v.

BRENT COAL CORPORATION,
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

APPEARANCES:[1]

Ron Carson
For Claimant

Ashby Dickerson, Esq.
For Employer/Carrier

BEFORE: STEPHEN L. PURCELL
Administrative Law Judge

DECISION AND ORDER - DENIAL OF BENEFITS

This proceeding arises from a claim filed by Donald Mack Quinley for benefits under the Black Lung Benefits Act, 30 U.S.C. §§ 901, *et seq.*, as amended (Act). In accordance with the Act, and the regulations issued thereunder, this case was referred to the Office of Administrative Law Judges by the Director, Office of Workers' Compensation Programs (OWCP). The regulations issued under the Act are located in Title 20 of the Code of Federal Regulations, and regulation section numbers mentioned in this Decision and Order refer to sections of that Title.

[1] The Director, Office of Workers' Compensation Programs was not represented at the hearing.

Benefits under the Act are awarded to persons who are totally disabled due to pneumoconiosis within the meaning of the Act. Survivors of persons who were totally disabled at their times of death or whose deaths were caused by pneumoconiosis also may recover benefits. Pneumoconiosis is a dust disease of the lungs arising out of coal mine employment and is commonly known as black lung disease.

A formal hearing in this case was held in Abingdon, Virginia on April 6, 2004. The findings and conclusions that follow are based on my observation of the demeanor and appearance of the witness who testified at the hearing and a careful analysis of the entire record in light of the arguments of the parties, applicable statutory provisions, regulations, and pertinent case law.

I. STATEMENT OF THE CASE

The Claimant, Donald Mack Quinley, filed his claim for benefits under the Federal Coal Mine Health and Safety Act of 1969, as amended, on March 28, 2001 (DX 2, 3).[2] Notices of Claim and Notices of Controversion were filed (DX 27, 29, 33, 35-37). On March 11, 2002, the District Director issued a Schedule for Submission of Additional Evidence (DX 39). The District Director issued a Proposed Decision and Order Denial of Benefits on July 26, 2002 (DX 52). The Claimant requested a hearing on August 20, 2002 (DX 55). The claim was referred to the Office of Administrative Law Judges on October 10, 2002 (DX 59). After multiple continuances requested by and granted to the Claimant, a hearing was held in Abingdon, Virginia on April 6, 2004.

II. ISSUES[3]

The specific issues remaining for resolution as noted on Form CM-1025 (DX 59) are as follows:

1. Whether the Miner has pneumoconiosis as defined by the Act and the regulations;

2. Whether the Miner's pneumoconiosis arose out of coal mine employment;

3. Whether the Miner is totally disabled; and,

4. Whether the Miner's disability is due to pneumoconiosis.[4]

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[2] In this Decision and Order, "DX" refers to the Director's Exhibits, "CX" refers to the Claimant's Exhibits, "EX" refers to the Employer's Exhibits, and "Tr." refers to the Transcript of the April 6, 2004 hearing.

[3] At the hearing, the Employer conceded 18 years of coal mine employment. In its January 2, 2003 letter, the Employer conceded that it was the responsible operator. I find that these concessions are supported by the evidence (DX 4-10).

III. FINDINGS OF FACT AND CONCLUSIONS OF LAW

Background

The Claimant, Donald Mack Quinley, was born in December 1954, and was 49 years of age at the time of the hearing (DX 2, 3; Tr. 15). He has an eleventh grade education (DX 2, 3). The Claimant married Willie Jean White on August 11, 2000 (DX 12). Mr. Quinley was previously married to Nancy Carol Farmer. They were divorced on October 29, 1985 (DX 13). The Employer has conceded (DX 58) that the Claimant has one dependent for purposes of augmentation of benefits, his wife, Willie Jean.

The Claimant smoked one-half pack of cigarettes per day from 1972 through the date of the hearing (Tr. 23; DX 38). I find that the Claimant has a smoking history of at least 16 pack-years.

Medical Evidence

A. X-ray Studies[5]

Dr. Fino, a B reader, interpreted an August 29, 2002 x-ray as completely negative (EX 1). Dr. Wiot, a B reader and Board certified radiologist, also read this x-ray as completely negative (EX 1).[6]

Drs. Cappiello and Alexander, both of whom are B readers and Board certified radiologists, interpreted a May 30, 2002 x-ray as 2/1 p,q (CX 1-2). Dr. Wheeler read the x-ray as negative for pneumoconiosis and stated that the x-ray was unreadable because the NIOSH does not allow classification of digital images (EX 9). Dr. Scatarige, a B reader and Board certified radiologist, also read this x-ray as negative and noted that the NIOSH does not allow classification of digital images (EX 10).

Dr. Poulos, a B reader and Board certified radiologist, read a May 8, 2002 x-ray as completely negative (DX 44).

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[4] The Employer also contested a number of issues identified in its September 20, 2002 letter (DX 58). Some of these issues are outside the scope of, and will not be addressed in, this Decision. However, these issues are preserved for appeal.

[5] Dr. Smiddy and Dr. Wheeler interpreted a June 23, 2003 x-ray (CX 1; EX 13). At the hearing, the Claimant and the Employer withdrew these interpretations from consideration (Tr. 10-11, 13). Consequently, these two interpretations will not be considered in this Decision.

[6] Dr. Fino reviewed a June 26, 2003 CT Scan and stated that "[t]here were no changes consistent with a coal mine dust associated occupational lung disease." (EX 14) Dr. Wheeler, a B reader and Board certified radiologist, interpreted an August 8, 2002 CT Scan as showing no pneumoconiosis (EX 2).

Dr. Patel, a B reader and Board certified radiologist, read a November 27, 2001 x-ray as 1/1 s,t (DX 21-22).[7] Dr. William Scott, Jr., a B reader and Board certified radiologist, read the November 27, 2001 x-ray as negative for the presence of pneumoconiosis (DX 45).

In a November 2, 2000 Discharge Summary (DX 44), Dr. Modi stated that a chest x-ray showed "multiple reticular nodular densities in both lungs with increase in interstitial markings suggestive of chronic changes, probably related to exposure to coal dust."

B. Pulmonary Function and Arterial Blood Gas Studies[8]

The record contains a June 30, 2003 pulmonary function study that produced qualifying results under the regulations (CX 3). Dr. Sarah Long reviewed these results on March 9, 2004 (EX 15). She stated that these results were invalid because "The curves show a very shallow initial slope and are very irregular. This is indicative of poor effort on the part of Mr. Quinley in performing the study. The technician noted that Mr. Quinley was unable to keep a tight seal around the mouthpiece. This would make it very unlikely that a valid study is possible."

The record contains pulmonary function studies administered on May 5, 2003, September 13, 2002, August 29, 2002, May 8, 2002, November 27, 2001, and November 1, 2000, all of which produced results that are non-qualifying under the regulations (DX 20; EX 11-12).

The record contains the results of arterial blood gas studies administered on August 29, 2002, May 8, 2002, November 27, 2001, February 26, 2001, and November 1, 2000 (DX 17, 20, 44; EX 1).[9] The November 27, 2001 arterial blood gas studies were performed at the direction of Dr. Rasmussen (DX 17, 20). The resting arterial blood gas study results failed to quality under the regulations but the exercise results did quality as showing total disability under the regulations. Dr. John Michos, a Board certified Internist and Pulmonologist, stated that the arterial blood gas study results were technically acceptable (DX 18-19).

C. Narrative Medical Evidence

1. Dr. Joseph F. Smiddy, a Board certified Internist, examined the Claimant on June 23, 2003 and June 30, 2003 (CX 3). He noted the Claimant's symptoms and his occupational and medical histories. Dr. Smiddy's examination of the Claimant was essentially normal. He noted a severe obstructive ventilatory defect evidenced by a pulmonary function study. Dr. Smiddy diagnosed "[m]ultiple lung nodules, possibly granulomatous, possible coal worker's pneumoconiosis, ongoing nicotine addiction, COPD, possible occult mild sleep apnea with underlying problems as noted."

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[7] Dr. Barrett, a B reader and Board certified Radiologist, confirmed that the November 27, 2001 x-ray was good film quality (DX 23-24).

[8] A "qualifying" pulmonary function study or blood gas study yields values that are equal to or less than the appropriate values set out in the tables at 20 C.F.R. Part 718, Appendices B, C, respectively. A "non-qualifying" study exceeds those values. *See* 20 C.F.R. § 718.204(c)(1)-(2).

[9] In a November 2, 2000 Discharge Summary, Dr. Modi stated that arterial blood gas and pulmonary function studies were unremarkable (DX 44).

2. Dr. Gregory Fino, a B reader and Board certified Internist, examined the Claimant on October 21, 2002 (EX 1). He noted the Claimant's symptoms and his occupational, medical, and family histories. Dr. Fino's examination of the Claimant was essentially normal. He conducted pulmonary function (normal) and arterial blood gas (elevated carboxyhemoglobin level) studies, and interpreted an x-ray (0/0). In addition, he reviewed the Claimant's medical records. Based on his examination of the Claimant and a review of the medical records, he opined that (1) simple coal workers' pneumoconiosis, of the clinical or legal variety, is not present; (2) there is a variable oxygen transfer abnormality present which is not disabling; (3) from a respiratory standpoint, the Claimant is neither partially nor totally disabled from returning to his last mining job or a job requiring similar effort; and (4) even if the Claimant suffered from pneumoconiosis, he is not totally disabled from a respiratory standpoint.

3. The record contains June 20, 2002 office notes completed by Dr. Husain (EX 3). Dr. Husain noted that "[c]essation of smoking was strongly urged" and the "[c]hest x-ray is not clearcut for CWP changes." He diagnosed right shoulder pain and shortness of breath.

4. The record contains Adult Forms from August 6, 2002 through December 20, 2002 that report results of physical examinations of the Claimant (EX 5).

5. Dr. David Rosenberg, a B reader and Board certified Internist and Pulmonologist, examined the Claimant on May 8, 2002 (DX 44). In addition, he reviewed the Claimant's medical records. He noted the Claimant's symptoms (cough, sputum, breathing problems, orthopnea, hemoptysis) and his occupational, medical, smoking (½ pack of cigarettes per day since age 19), and family histories. Dr. Rosenberg's examination of the Claimant was essentially normal. He conducted pulmonary function (non-qualifying) and arterial blood gas (increased carboxyhemoglobin level) studies, and administered an x-ray (negative) and EKG (no particular abnormalities). Dr. Rosenberg opined that the Claimant has a disabling respiratory condition that is likely caused by his smoking. He concluded that "[t]he progression of [the Claimant's] symptoms over the last 2 to 3 years, obviously while conceivably related to the presence of CWP, would be uncharacteristic of this condition with him having been removed from the work place. In addition, conglomeration was not present on his chest X-ray. Mr. Quinley clearly needs to stop smoking."

6. Dr. D.L. Rasmussen, a Board certified Internist, examined the Claimant on November 27, 2001 (DX 15). He noted the Claimant's symptoms (sputum, wheezing, dyspnea, cough, hemoptysis, chest pain, orthopnea, paroxysmal nocturnal dyspnea) and his occupational, medical (frequent colds, attacks of wheezing, arthritis, allergies, diabetes mellitus, cancer, high blood pressure, connective tissue disease), smoking (½ pack of cigarettes per day since 1972), and family (high blood pressure, heart disease, diabetes, cancer, asthma, emphysema) histories. Dr. Rasmussen's examination of the Claimant was essentially normal. He conducted pulmonary function (normal) and arterial blood gas (marked impairment in oxygen transfer during exercise) studies, and administered an x-ray (1/1 s,t). Dr. Rasmussen diagnosed (1) coal workers' pneumoconiosis based on the Claimant's coal mine employment and x-ray evidence of pneumoconiosis; and (2) chronic bronchitis based on the Claimant's chronic productive cough. Dr. Rasmussen identified coal mine dust exposure as the etiology of the Claimant's coal

workers' pneumoconiosis and listed coal mine dust exposure and cigarette smoking as the etiology of the Claimant's chronic bronchitis. Dr. Rasmussen opined that the Claimant does not retain the pulmonary capacity to perform his last regular coal mine job due to his very poor exercise tolerance and marked loss of lung function. He concluded that the Claimant's coal mine dust exposure is the predominant cause of his impairment as "reflected by his normal ventilatory capacity, but marked impairment in oxygen transfer."

7. The record contains treatment and progress notes that reference the Claimant's symptoms and medications (DX 44). In June 7, 2001 progress notes, the physician notes that the Claimant was advised to quit smoking.

8. The record contains a History & Physical and a Discharge Summary from 2000 (DX 44). Based on a physical examination, Dr. Vinod Modi diagnosed (1) chest pain, uncontrolled angina pectoris, stabilized; (2) essential hypertension; (3) tobacco abuse; (4) severe low back pain; and (5) chronic tension headaches.

9. The record contains a September 9, 1999 Out-Patient Medical Record completed by Dr. Patel (EX 4). An EKG revealed normal sinus rhythm.

Pneumoconiosis

In order to establish entitlement to benefits, the Claimant must establish that he suffered from pneumoconiosis, that the pneumoconiosis arose out of coal mine employment, and that the pneumoconiosis was totally disabling. *See* 20 C.F.R. §§ 718.202, 718.203, 718.204; *Trent v. Director, OWCP*, 11 B.L.R. 1-26 (1987). Failure to establish any of these elements precludes entitlement. *Perry v. Director, OWCP*, 9 B.L.R. 1-1 (1986) (*en banc*).

Section 718.202(a)(1-4) provides four methods for finding the existence of pneumoconiosis: (a)(1) chest roentgenogram (x-ray) evidence; (a)(2) autopsy or biopsy; (a)(3) by operation of presumption; or (a)(4) by other relevant evidence (medical opinions). There is no autopsy or biopsy evidence of record and none of the pneumoconiosis presumptions are applicable in this case. Thus, the Claimant can establish pneumoconiosis through either x-ray evidence or medical opinion evidence.

A judge is not required to defer to the numerical superiority of x-ray evidence. *Wilt v. Wolverine Mining Co.*, 14 B.L.R. 1-70 (1990). Where two or more x-ray reports are in conflict, the radiological qualifications of the physicians interpreting the x-rays should be considered. *Aimone v. Morrison Knudson Co.*, 8 B.L.R. 1-32 (1985). Greater weight may be accorded the x-ray interpretation of a dually-qualified (B-reader and board certified radiologist) physician over that of a board certified radiologist. *Herald v. Director, OWCP*, BRB No. 94-2354 BLA (Mar. 23, 1995) (unpublished).

The record contains interpretations of 5 x-rays. Dr. Fino, a B reader, and Dr. Wiot, a B reader and Board certified radiologist, interpreted an August 29, 2002 x-ray as negative for the presence of pneumoconiosis (EX 1). Dr. Poulos, a B reader and Board certified radiologist, interpreted a May 8, 2002 x-ray as completely negative (DX 44). Based on the interpretations by

these 3 highly qualified physicians, I find that the August 29, 2002 and May 8, 2002 x-rays are negative for the presence of pneumoconiosis. Drs. Cappiello and Alexander, both of whom are dually qualified as B readers and Board certified radiologists, read the May 30, 2002 x-ray as positive for the presence of pneumoconiosis (CX 1-2). However, Drs. Wheeler and Scatarige, both of whom also are dually qualified, opined that the May 30, 2002 x-ray was negative for the presence of pneumoconiosis. Also, they opined that the x-ray did not comply with the NIOSH classification system (EX 9-10). Weighing these four interpretations, I find that the May 30, 2002 x-ray is at best equivocal regarding the presence of pneumoconiosis and I give the x-ray little weight. Dr. Patel, a B reader and Board certified radiologist, read a November 27, 2001 x-ray as 1/1 (DX 21-22). Dr. Scott, a B reader and Board certified radiologist, read the November 27, 2001 x-ray as negative for the presence of pneumoconiosis (DX 45). I find that the opinion of Dr. Scott is entitled to at least as much weight as the opinion of Dr. Patel. Consequently, I find that the November 27, 2001 x-ray is equivocal regarding the presence of pneumoconiosis and is entitled to little weight. In a November 2, 2000 Discharge Summary (DX 44), Dr. Modi stated that a chest x-ray showed "multiple reticular nodular densities in both lungs with increase in interstitial markings suggestive of chronic changes, probably related to exposure to coal dust." The record does not contain an ILO Classification sheet addressing this x-ray. Further, Dr. Modi's statement that the changes are "probably related to exposure to coal dust" is equivocal at best. Therefore, I give Dr. Modi's x-ray interpretation little weight.

Based on the interpretations by these highly qualified physicians, I find that the August 29 and May 8, 2002 x-rays are negative for the presence of pneumoconiosis. The remaining x-rays are equivocal regarding the presence of pneumoconiosis. Therefore, the Claimant has failed to establish the existence of pneumoconiosis by a preponderance of the x-ray evidence.

The record contains a number of medical opinions. For a physician's opinion to be accorded probative value, it must be well-reasoned and based upon objective medical evidence. An opinion is reasoned if it contains underlying documentation adequate to support the physician's conclusions. *See Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). Proper documentation exists where the physician sets forth the clinical findings, observations, facts, and other data on which the diagnosis is based. *Id.* A brief and conclusory medical report which lacks supporting evidence may be discredited. *See Lucostic v. United States Steel Corp.,* 8 B.L.R. 1-46 (1985); *see also, Mosely v. Peabody Coal Co.*, 769 F.2d 357 (6th Cir. 1985).

Dr. Smiddy diagnosed "[m]ultiple lung nodules, possibly granulomatous, possible coal worker's pneumoconiosis, ongoing nicotine addiction, COPD, possible occult mild sleep apnea with underlying problems as noted." (CX 3). The x-ray interpretation by Dr. Smiddy was withdrawn from consideration by the Claimant (Tr. 10-11). Dr. Middy's "possible coal worker's pneumoconiosis" diagnosis is equivocal at best. Further, Dr. Smiddy failed to connect his COPD diagnosis with the Claimant's coal mine employment. Given the inadequate rationale and support for his equivocal diagnosis of "possible coal worker's pneumoconiosis," I give Dr. Smiddy's opinion little weight.

Dr. Fino examined the Claimant and reviewed the Claimant's medical records. Based on his examination and review of the records, he opined that the Claimant did not suffer from coal

workers' pneumoconiosis. I find that his opinion is supported by the objective medical evidence of record and is well explained. Consequently, I give his opinion substantial weight.

Dr. Rosenberg examined the Claimant and reviewed medical records (DX 44). He concluded that "[t]he progression of [the Claimant's] symptoms over the last 2 to 3 years, obviously while conceivably related to the presence of CWP, would be uncharacteristic of this condition with him having been removed from the work place." While this opinion weighs against a finding of pneumoconiosis, I entitle it to less weight than the opinion of Dr. Fino because Dr. Rosenberg failed to give as definite of an opinion as to the presence or absence of pneumoconiosis.

Dr. Rasmussen examined the Claimant and diagnosed (1) coal workers' pneumoconiosis based on the Claimant's coal mine employment and x-ray evidence and (2) chronic bronchitis caused by the Claimant's coal mine employment and cigarette smoking. His diagnosis of coal workers' pneumoconiosis is against the weight of the x-ray evidence. However, his diagnosis of chronic bronchitis caused by coal mine employment constitutes legal pneumoconiosis. This opinion is supported by his examination of the Claimant and is entitled to some weight.

Based on a review of the medical opinion evidence, I find that the opinion of Dr. Fino is entitled to at least as much weight if not more than the opinion of Dr. Rasmussen. Consequently, I find that the Claimant has failed to prove by a preponderance of the evidence that he suffers from pneumoconiosis. Therefore, his claim must fail.

Total Disability

Assuming the Claimant had established that he suffered from pneumoconiosis, the regulations at §718.204(b) provide the following five methods to establish total disability: (1) pulmonary function (ventilatory) studies; (2) blood gas studies; (3) evidence of cor pulmonale with right-sided congestive heart failure; (4) reasoned medical opinions; and (5) lay testimony. 20 C.F.R. §718.204(b) (2000) and (2001). In addition, under 20 C.F.R. §718.304 (2001), there is an irrebuttable presumption that a miner is totally disabled due to pneumoconiosis if the miner is suffering from complicated pneumoconiosis.

Only the June 30, 2003 pulmonary function study produced qualifying results under the regulations. The results of this study were questioned by Dr. Sarah Long. The remaining pulmonary function studies failed to produce qualifying results. In addition, there were arterial blood gas studies of record that produced qualifying results. In fact, Dr. Michos, a Board certified Internist and Pulmonologist, stated that the November 27, 2001 study that produced qualifying results was technically acceptable. Moreover, the medical opinions of Dr. Rasmussen and Rosenberg support a finding of total disability. Dr. Rasmussen opined that the Claimant does not retain the pulmonary capacity to perform his last regular coal mine employment due to his very poor exercise tolerance and marked loss of lung function. His opinion on this issue is supported by the objective medical evidence and is well explained. Consequently, I give his opinion on this issue substantial weight. Dr. Rosenberg opined that the Claimant has a disabling respiratory condition. His opinion on this issue is supported by the objective medical evidence.

Dr. Fino opined that the Claimant is not disabled from a respiratory or pulmonary standpoint. However, he did note that the Claimant suffered from a variable oxygen transfer abnormality.

Weighing the results of the pulmonary function and arterial blood gas studies, along with the medical opinions, I find that the Claimant has established that he suffers from a totally disabling respiratory impairment that would prevent him from performing his last coal mine employment or job requiring similar effort.

Etiology of Total Disability

Prior to the 2000 Amendments, in order to recover under the Act, a claimant had to prove that pneumoconiosis was a "contributing cause" to the miner's disability. *Hobbs v. Clinchfield Coal Co.*, 917 F.2d 790, 792 (4th Cir. 1990); *Robinson v. Pickands Mather & Co.*, 914 F.2d 35, 38 (4th Cir. 1990). In *Milburn Colliery Co. v. Director, OWCP [Hicks]*, 138 F.3d 524 (4th Cir. 1998), the court held that even if it is determined that Claimant suffers from a totally disabling respiratory condition, he "will not be eligible for benefits if he would have been totally disabled to the same degree because of his other health problems."

The amended regulations at § 718.204(c) contain the following standard for determining whether total disability is caused by the miner's pneumoconiosis:

> (c)(1) Total disability due to pneumoconiosis defined. A miner shall be considered totally disabled due to pneumoconiosis if pneumoconiosis, as defined in Sec. 718.201, is a substantially contributing cause of the miner's totally disabling respiratory or pulmonary impairment. Pneumoconiosis is a "substantially contributing cause" of the miner's disability if it: (i) Has a material adverse effect on the miner's respiratory or pulmonary condition; or (ii) Materially worsens a totally disabling respiratory or pulmonary impairment which is caused by a disease or exposure unrelated to coal mine employment.
>
> (2) Except as provided in Sec. 718.305 and paragraph (b)(2)(iii) of this section, proof that the miner suffers or suffered from a totally disabling respiratory or pulmonary impairment as defined in paragraphs (b)(2)(i), (b)(2)(ii), (b)(2)(iv) and (d) of this section shall not, by itself, be sufficient to establish that the miner's impairment is or was due to pneumoconiosis. Except as provided in paragraph (d), the cause or causes of a miner's total disability shall be established by means of a physician's documented and reasoned medical report.

20 C.F.R. § 718.204(c) (Dec. 20, 2000).[10]

[10] In its comments, the Department noted that addition of the word "material" or "materially" to the foregoing provisions reflects the view that "evidence that pneumoconiosis makes only a negligible, inconsequential, or insignificant contribution to the miner's total disability is insufficient to establish that pneumoconiosis is a substantially contributing cause to that disability." Regulations Implementing the Federal Coal Mine Health and Safety Act of 1969, 65 Fed. Reg. 79,946 (Dec. 20, 2000).

Dr. Rosenberg opined that the Claimant has a disabling respiratory condition that is likely caused by his smoking. Although he noted that the worsening of the Claimant's condition could "conceivably" be related to pneumoconiosis, he concluded that it was more likely due to the Claimant's lengthy smoking history. I find that his opinion is supported by the objective medical evidence and is well explained. Consequently, I give it substantial weight on this issue.

Dr. Fino failed to diagnose a totally disabling respiratory impairment and did not opine on the etiology of the Claimant's disabling respiratory impairment. Consequently, I give his opinion little weight on the issue of etiology.

Dr. Rasmussen concluded that the Claimant's coal mine dust exposure is the predominant cause of his impairment as "reflected by his normal ventilatory capacity, but marked impairment in oxygen transfer." His opinion is supported by his examination of the Claimant. I find that the opinion of Dr. Rosenberg is as well explained and well supported as the opinion of Dr. Rasmussen. Consequently, I find that the Claimant has failed to prove by a preponderance of the evidence that his total disability is due to pneumoconiosis.

IV. ENTITLEMENT

Upon consideration of all of the evidence of record, I find that the Claimant, Donald Mack Quinley, has failed to meet his burden of proof on all elements of entitlement under the Act, and therefore, is not eligible for benefits.

V. ATTORNEY'S FEES

The award of an attorney's fee under the Act is permitted only in cases in which the claimant is found to be entitled to benefits under the Act. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to the Claimant for services rendered to him in pursuit of this claim.

VI. ORDER

It is hereby ordered that the claim of Donald. Mack Quinley for benefits under the Act is hereby DENIED.

A

Stephen L. Purcell
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within thirty (30) days from the date of this Decision by filing a Notice of Appeal with the **Benefits Review Board at P.O. Box 37601, Washington, D.C., 20012-7601**. A copy of a Notice of Appeal must also be served upon Donald S. Shire, Esq., 200 Constitution Avenue, N.W., Room N-2117, Washington, D.C., 20210.